



## Covid-19 Test Kit Reimbursement Claim Form

### Important!



- Always allow 30 days from the time you receive the response to all work claims processing and delivery.
- Keep copies of all documents submitted for your records.
- Do not staple receipts or attachments to this form.
- Reimbursement is not guaranteed and the contractor will review the claims subject to limitations, exclusions and provisions of the plan.

### STEP 1 Card Holder/Patient Information

This section must be fully completed to ensure proper reimbursement of your claim.

#### Card Holder Information

Identification Number (refer to your ID card)	Group Number/Group Name		
<input type="text"/>	<input type="text"/>		
Last Name	First Name	MI	
<input type="text"/>	<input type="text"/>	<input type="text"/>	
Address			
<input type="text"/>			
Address 2			
<input type="text"/>			
City	State	Zip Postal Code	Country
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

#### Patient Information—Use a separate claim form for each patient

Last Name	First Name	MI
<input type="text"/>	<input type="text"/>	<input type="text"/>
Date of Birth	Phone Number	
<input type="text"/>	<input type="text"/>	
Relationship	Member	
<input type="radio"/> Primary Member <input type="radio"/> Member <input type="radio"/> Other	<input type="radio"/> Member <input type="radio"/> Non-Member	<input type="text"/>

## Important! A signature is REQUIRED

### NOTICE

Any person who knowingly and with intent to defraud, injure, or deceive any insurance company, submits a claim or application containing any materially false, deceptive, incomplete or misleading information pertaining to such claim may be committing a fraudulent insurance act which is a crime and may subject such person to criminal or civil penalties, including fines, denial of benefits and/or imprisonment.

OTC test(s) were purchased for personal use, not employment, has not been reimbursed by another source, and is not for resale.

I certify that I (or my eligible dependent) have received the medicine described herein. I certify that I have read and understood this form, and that all the information entered on this form is true and correct.

**K**

Signature of Patient (REQUIRED)

Date

## STEP 2 Submission Requirements

You MUST include all original pharmacist cash register receipts or n-line of purchase in order for your claim to process. The minimum information that must be included on your pharmacist cash register receipts or n-line of purchase is listed below:

- Date of Purchase
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